North Coast Physician

In This Issue:

Cover Photo
"Hula Hoops At The Park 2"
Stephen Kamelgarn, M.D.

The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication.

North Coast Physician is published monthly by the **Humboldt-Del Norte County Medical Society**, 3100 Edgewood Road, P.O. Box 6457, Eureka, CA 95502. Telephone: (707) 442-2367; FAX: (707) 442-8134;
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Infantile Drug Addicts

Emily Dalton, M.D.

Humboldt County is seeing a new influx of an old drug: heroin. The number of infants born addicted is rising, and the lengthy hospitalizations required for detoxification are painstaking and expensive. Imagine 8 hour shifts with tremulous, sweaty, stuffy, irritable, shrieking, vomiting infants who are unable to sleep and have profuse diarrhea. Well, our intensive care nurses don't have to imagine it--they live through it.

Methamphetamine is a terrible scourge as well. Recently a meth- exposed infant was born with so many cerebral infarcts that it didn't even have enough brain function to suck or swallow. Who cares for these devastated children?

This February in Eureka, a woman pleaded guilty to manslaughter after her breastfed infant died of a methamphetamine overdose. What a tragedy.

As I was rounding in the nursery one morning surrounded by the din of numerous screaming newborns, I got a few novel ideas that might help address this issue. (Mike Thompson, I hope you ARE reading this editorial) The beauty of these suggestions is that that they are equally offensive to all types: liberal people, conservative people, religious people, older people and corporate people.

1. Put the methadone in birth control pills (This solves the problem of missed pills as well!)

2. Pay $50 cash for anyone receiving a Depo shot.

3. Pay $150 cash to anyone getting an IUD

4. Pay $300 cash to anyone receiving a 5-year Norplant.

5. Pay $500 cash to anyone getting a vasectomy (gotta include the men in this)

Contraception:

Genesis 1:22 says "God blessed them saying, 'Be fruitful and multiply and fill the waters in the seas, and let birds multiply on the earth.'" How this passage can be construed as a prohibition against the use of birth control is a conceptual leap I am unable to follow. Currently by United Nations estimates, the country with the highest population growth rate is Liberia, at 4.5%.

Let's imagine that everyone in Humboldt County decided to forswear any form contraception, AND, that there was no decrease the human sex drive or increase in mortality rates. A simplistic formula to calculate future population is:

Pf=Pp x (1+i)n; where:

Pf is the future population
Pp is the present population
i is the growth rate
n is the number of years

In 2010 Humboldt County boasted a population of 134,794. With no curb whatsoever on fertility, let's conservatively assume a growth rate of 6%--not even twice that of Libera. With these assumptions then:

In 5 years our population would reach 151,601

In 8 years we would be at 5,899,595

By 10 years our population would be 282,610,043

That would be pretty irresponsible of us. (we'd need a lot more pediatricians) (and there would be no room for any birds, either)

Nutrition:

Pay qualifying women who breastfeed the money would have been spent on subsidized formula had they chosen to bottle feed, and watch the breastfeeding rate soar! (while formula profits plummet)

Aging:

Anyone licensed driver over the age of 65 must pass the same driving test given to teenagers --annually.

References:

1. http://www.times-standard.com/localnews/ci_19909292

2. http://en.wikipedia.org/wiki/List_of_countries_by_population_growth_rate

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Did You Know....

The Medical Society offers NOTARY PUBLIC services for our members at no charge.

"Frank"

STEPHEN KAMELGARN, M.D.

My first job, after finishing my internship (but before my residency), was the payback of my Public Health scholarship, on an Indian Reservation in Northeastern Montana. In 1979, I went from the "Pele designed Hell" of my internship at the University of Hawaii, immediately to a place that was "120 miles from the nearest mirage." Poplar, Montana was located on the Missouri River: 60 miles from the Canadian border and 60 miles from the North Dakota state line. I had gone from viewing the endless undulating tropical blue Pacific to viewing the endless undulating brown and yellow hills of the Great Plains. Talk about culture shock. Poplar was the headquarters of the Fort Peck Sioux Reservation and was to be my wife's and my home for the next two of years.

The Fort Peck Sioux Reservation was a Bureau of Indian Affairs forced shotgun marriage of two tribes who had been enemies for centuries: the Assiniboine and the Medicine Bow Sioux. Then, if that wasn't interesting enough, in about 1920, the BIA threw the reservation open to White Homesteaders and settlers. This made the community "multifaceted."

Needless to say it was an interesting place to be, especially since I was the National Health Service Corps doctor for the non-Natives--the Native people were served by the 24,000 square foot Indian Health Clinic that was directly across the parking lot from my small, two-exam room office. That clinic was staffed by three other payback docs, working for the Indian Health Service, and they were nice enough to let me into their call schedule, so I was only on call every fourth night, rather than 24/7.

One beautiful Autumngold Saturday afternoon I was on call, sitting home playing with our dog and semi-watching a football game on the tube, when my wife, a nurse at the small 20 bed hospital, called me to let me know that she had received a call from a guy who was having "a little chest pain." I told her to go ahead, call in the X-ray/lab tech (the same person), get the EKG machine set up, along with an IV, and I'd be right over. I got to the hospital about five minutes before the patient, so I had a little time to make sure we were as prepared as we could be.

I soon saw an old pick-up truck pull into the parking lot, the door opened, and I heard, what sounded like a freight train coming out of the driver's side window. I'd never heard a sound like that, coming from a car, before. I soon saw a 6' 1", 260 lb. farmer emerging from the driver's side. He was wearing a pair of bib overalls over his bare chest, and this waterfall of pink froth was pouring out of his mouth. His skin was almost the color of his overalls, and it was immediately obvious, even to me three months out of my internship, that this guy was in florid pulmonary edema; "a little chest pain!" indeed. We had no wheeled gurney, and as I was walking him from his car into our one bed ER, I noted that he had an external A-V dialysis shunt in his left forearm.

"Do you make any urine at all, Frank?" I had at least gotten his name (not his real name).

Gasp, gasp, "a" gasp, "little," gasp, gasp, "Doc." Well, I guess my hands were full. Someone in severe CHF, 200 air miles from his dialysis unit in Billings--so diuretics probably wouldn't work for this guy. Our nearest blood gas machine was 35 miles away in Wolf Point, and our single ventilator was either broken or in use (I can't remember).

Thing's started looking even worse when we found that he had a BP of 210/120, and he had something like 10mm of ST elevation in leads II, III and F. As all this information came flooding in and I began having a major meltdown, I suddenly remembered a little lecture I had gotten late one night on the history of treating CHF, by one of my residents when I was on call, as a 3rd or 4th year student. I recalled the mnemonic, MOST DAMP, that house staff learned back in the 1940's and 50's for treating CHF, before we got so high tech: M (Mercurial diuretics); O (Oxygen); S (Sitting upright); T (rotating Tourniquets); D (Digitalis); A (Aminophylline); M (Morphine); P (Percussion).

Well, I got him sitting up, put some oxygen on him--blood gases not available, and the cutaneous oxygen sensor not yet invented--and prayed that he also didn't have COPD and was a CO2 retainer. I started an aminophylline drip, something that I was very familiar with, having run dozens of aminophylline drips on asthmatic kids when I did pediatrics as an intern. We put on rotating tourniquets, gave him some IV digoxin, and tried to do something about his blood pressure. ACE inhibitors and Calcium Channel Blockers hadn't been invented yet, and, in those days, Beta blockers were strongly contraindicated in CHF. Again, I dredged up some memories of something, gave the patient a dose of Hyperstat, and some IV Hydralazine. He wound up receiving more fluid in the form of IV Lasix than he put out as urine.

But something worked, and within

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about 15 minutes he had gone from blue to pink, his blood pressure had come down to about 150 systolic, and we were able to get him on the airplane, and I transported him down to Billings for dialysis.

We had about an hour flight down to Billings, and Frank was comfortable enough to talk about himself. His grandfather came out when the BIA threw the Rez open to Caucasians in the early 1920's. He was a farmer that grew Winter Wheat that was getting ready for harvest. Migrant Mexican Laborers and poor Caucasian men did the bulk of the harvesting. Little did I think that I would be using my Spanish in that godforsaken corner of Montana. He seemed to get along well with the Native People on the reservation, but I only had his word to go on. He couldn't imagine doing anything else, and was really enjoying himself despite his various illnesses.

He had lost his kidneys to diabetes a couple of years earlier, and had spent the last two years flying down to Billings three days a week for the ½ day long dialysis treatments.

"Doesn't it get to be a drag flying down to Billings and back three days a week?"

"Nah, it's ok. Gives me time to catch up with Dallas (our only pilot), look at the scenery and think."

"What about the farm?"

"Well, the farm sort of runs itself, and even if I was home I'd be too sick to do much of anything. So, my wife does most of running the place." Dallas confirmed that Frank was telling the truth and was genuine in his feelings, and I sat back wonderfully astounded. It was a real "Aha" moment. I saw so many things so differently--a whole new phase of my education had begun.

We got Frank off the plane in Billings; he was met at the airport by hospital staff, so Dallas and I took off immediately, and I never got to meet his Billings doc. Besides, I was on call and had to get back to Poplar.

Frank survived that bout of heart failure, and passed away in his sleep about two months later. I went out to his place a couple of times before he died, just to see how he was doing, so I got to know him a little better. I loved listening to his tales, and I was usually able to stretch the visit to about 45 minutes or so. He knew a lot of local history, from the Caucasian point of view, and helped enlighten me to a lot of aspects about life on the Rez. Although he knew he was extremely ill and didn't have long to live, he had a real joy about "stuff," and enjoyed sharing it. Unfortunately, I was at a medical conference in Salt Lake City when Frank passed away, so I missed his funeral, much to my regret.

My short exposure to Frank was such an eye opening satori on the diversity of the human condition. People, despite serious illness and adversity could find purpose and meaning in the little things. In that corner of Montana there was a cultural acceptance of Death and dying that I never could have believed possible, prior to my moving there. And, that acceptance could be both empowering and life affirming. Frank personified all that.

To me, he encapsulated all that was my Montana experience: a smart aleck medical neophyte, thrown into a whole new world; flying without a safety net or parachute. I learned to rely on my wits and ability to improvise. I discovered a beautiful part of the country that actually had four seasons, and Autumn was golden glorious. Winters, on the other hand. . .

But most important, I got to know, both medically, and as friends, a completely different group of people. People I had never thought existed or I could have dreamed of. . .and they were the most wondrous people. §

KEEP US UP-TO-DATE

Have you changed your E-Mail Address? ....or posted a web page for your practice? Please let the Medical Society know so that we can update our records and link to your page from the Medical Society's Web Page.

Have you looked at the Medical Society Web Page lately? Comments/ Suggestions are always welcome.

Humboldt-Del Norte California Physicians For A National Health Program Update

Corinne Frugoni, M.D.

What would it mean to have a single payer health care system in California? On March 24, Dr. Bill Skeen, the executive director of Physicians for a National Health Program -California, addressed the second meeting of the Humboldt-Del Norte chapter of PNHP -California. Over coffee and bagels, Dr. Skeen discussed the history of PNHP-California, strategies for action, and coalition building. He presented the material in a very thoughtful and articulate manner and energized the group with some great ideas for education and action.

The national PNHP has over 18,000 members. PNHP California has around 3000 members and an additional 3000 medical student members. Dr. Skeen emphasized that the purpose of PNHP California is to educate and advocate for a Single Payer Health Care System for all Californians. A local chapter with 8 charter members was officially created, bringing the total of regional members to 26.

PNHP California is a member of a state-wide coalition called "Campaign for a Healthy California." Other members include California Health Professionals Student Alliance, Health Care for All, Single Payer Now, California One Care, California Nurses Association (CAN) and California Association of Retired Americans (CARA).

A single payer health care system would provide Medicare for all Californians, with major organizational improvements in administration and delivery of health care . Single payer would provide an infrastructure for how we pay for care but would not change how we deliver care. California would continue to have a competitive mix of public and private providers. All Californians would have complete freedom to choose their health care providers. Eligibility would be based on residency and not on income or employment.

Currently, one of seven dollars paid to a medical office or clinic is used in turn to collect payment- for contracting, billing, co-payment collection, and the too-familiar claim denials appeals. On the other side, the private for-profit health insurance companies spend 38 cents of each dollar they collect for administration and profits. That leaves only 62 cents for clinical care. At least 20 cents of that 38 cents could be re-invested into health care under a single payer system by cutting out the for-profit insurance companies' stockholder profits, the excessive salaries of the CEOs and the exorbitant monies spent on marketing. Most importantly, a single payer health system would eliminate waste by consolidating the functions of many insurance companies into one comprehensive insurance plan administered by a public agency. This public agency would be held accountable to both consumers and providers of health care. A hierarchy of committees composed of local and regional elected and appointed officials including health care professionals would represent both health care provider and consumer concerns. Costs would be controlled through negotiated fees, global budgeting, bulk purchasing and economic and public health planning. Planning for health care needs, and not profit—what a concept.

Because of the money saved on administrative costs, and by eliminating private profits, under a single payer system, all Californians would be covered for all medically necessary services, including hospital, medical, surgical, and mental health services, skilled nursing care after hospitalization, dental and vision care, prescription drugs and medical equipment such as hearing aids, substance abuse recovery programs, health education, translation services and hospice care. Evidence based complementary therapies would also be included. Is there any existing insurance policy that provides such comprehensive services? With single payer, all of these services would be available without co-pays or deductibles.

One myth promoted by people and organizations opposed to single payer is that establishing a single payer system in California is a pipe dream. Single payer bills passed both state houses in 2006 and 2008 but were vetoed by then-Governor Schwarzenegger. The most recent single payer health care bill, SB 810 lost the center floor vote by only 2 votes in January 31st of this year. Governor Brown has indicated interest in single payer if it can be shown to reduce costs. CMA's position has progressed from outright rejection to recognition of single payer as a valid option that requires further analysis. Looking across our borders to the East, Vermont has passed a "Green Mountain Care-A roadmap to Single Payer" that will be implemented in 2017.

If you still have questions, consider coming to a chapter meeting. All are welcome to attend. You do not need to be a physician. For directions or more information call 822-3141 or e-mail cfrugoni@reninet.com. . If you are unable to attend, you can join PNHP California on line at pnhpcalifornia.org. This website is also a great source of information. Additional websites that are very informative are www.pnhp.org and www.healthycaliforniacampaign.org. §

A Day in the Life of a Hospitalist

JENNIFER HEIDMANN, MD

Facility Medical Director, TeamHealth West, St Joseph Hospital

"Never judge a man (or woman) until you have walked two moons in their moccasins"- old Proverb

Recently, Dr Miller, our Patient Safety Officer, took a team of people to watch a medication order from being placed by a physician all the way down to pharmacy and back to the patient. One thing we all learned from his team's exercise: there is a lot of unseen work behind the scenes! This exercise led to improvements in the flow, especially down in the pharmacy which was particularly burdened, and hopefully will also lead to improved quality of care.

This also got me thinking about how little each of us really knows about what eachother's days are like. I have some idea of the primary care day (in a nutshell: hard!), because I lived it. I recall deciding to be an internist as a med student and when people asked what that was, exactly, I found it quite difficult to explain. Sometimes I still do, (doctors for adults? the OCD poster children of the world of medicine? the most thrilled by a very long and improbable list of differential diagnoses? the best dressers?) but at least I can tell you how a typical day is for a hospitalist.

7:00 AM The night shift hospitalist signs out. 6 patients came in over night, some of whom we know well (it can feel like primary care sometimes). Most of the 60 patients they cross-covered last night were quiet, but Mr Smith's* respiratory status worsened and he had to go on BiPAP. Someone should look at him early this morning.

7:45 AM The patients have been distributed to the team. I get a call from the house supervisor RN: "Please tell your team to transfer patients off PCU! And do you have some discharges? We need beds ASAP!" I need to see Mr Smith. Then I will run my patient's labs and vitals, and then I go to PCU and do some transfers and discharges.

9:30AM Ms Jones* on the 4th floor wants to leave AMA. I stop what I am doing and run up the stairs. I am worried that the cellulitis will get out of control without more IV antibiotics in this homeless patient who is heroin addicted. There is a lot of heroin on our streets these days! I can't talk her into staying, but I get some charity meds for her (which our hospital does frequently) and try to get her follow up at the Mobile Medical Clinic. I hope she goes.

11:45 AM We have 4 admissions waiting in the ER and 1 direct admission from a clinic. But I am really hungry. A couple of us head to the doctors' lounge to shovel down some food and commiserate with our colleagues. Someone tells me how excited they are to start CPOE. I almost choke on my tater tot.

1:00 PM Mr Smith's blood gas is still not improving, and he is tiring out. He really does not want to be intubated. His wife is struggling with this. I call Dr Fratkin, our Palliative Care specialist. He spends 90 minutes at the bedside with the patient and his family. He calls the PCP. They opt to go off BiPAP and focus on comfort.

3:00 PM I discharged 6 people so far. The CPOE discharges are getting faster, and I like that my instrucions and prescriptions show up instantly in Meditech for the PCPs. I swing by Mr Smith's room. He looks comfortable. His children are laughing with him, through their tears.

5:50 PM My shift ends in 10 minutes but I have another admit to do, and some loose ends to tie up. There are 4 more admissions in the ER. The swing shift hospitalists (9-9) work side by side with me on the admits. I wish I spoke Hmong. There is a translator phone, and I am always surprised by how well this works. Patients appreciate it.

8:00PM I check on some studies, and answer questions when stopped by a patient's family member in the hallway. Then I sign out my to-do's and worries to the swing person who will relay it to nights.

9:00 PM Night shift arrives. They take sign out. They admit 8 patients over night. They get a lot of phone calls. They are worried about a dissecting aneurysm in one of their patients. One of their patients was a consult in the OB department. The history was challenging as she was in active labor and certainly had no special interest in the hospitalist at that moment. They check in on Mr Smith to make sure he is comfortable.

7:00 AM I return. I pat the night doc on the back: 8 admits is a lot. There were some very interesting cases though. I strap on my moccasins, and get to work.

Stay tuned for an invite to a summer dinner between the hospitalists and Primary Care Providers. More
on that soon.

Respectfully,
Jennifer Heidmann

*Mr Smith and Ms Jones are imaginary patients

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BOARD BRIEFS..... MARCH

M/S/C to approve the following items in the "Consent Calendar", as presented:

-Reading of the Minutes (2/15/12), approve as presented.
-Membership Committee Meeting (1/9/12), approve as presented.
-Finance Committee Meeting (3/7/12), approve as presented.
-Physician Well Being Committee (3/13/12), approve as presented.
-Editorial and Publications Committee (3/14/12), approve as presented.
-Physician Data Snapshot, review/file.
-AB1745 CMA Sponsorship, review/file.
-CMA Legal Case Review, review/file.
-CMA Regulation Quicklist, review/file.
-Prop 29 Endorsement CMA, review/file.

REPORTED receiving comments back from CMA. Bylaws Committee will meet to discuss recommendations for presentation to the Executive Board.

REVIEWED Editorial and Publication Committee's communication to Congressional Candidates for feedback on their views regarding Health Care Reform - for publication in North Coast Physician.

REPORTED submitting nomination of Jeffrey Ribordy, M.D. for the CMA Committee on Information Technology.

REPORT presented on 2012 Committees - duties and membership. Noted that the list is also published in the Physician Membership Resource Directory.

M/S/C to follow up with CMA Foundation re: possible grant funding to work on promoting of the "Walk With A Doc" Program locally. Suggested coordinating any activities through the Membership Committee.

M/S/C to continue working with the consultant in the submission of the HPSA applications.

M/S/C to approve the application of:

-Christopher Walter, D.O., Orthopaedic Surgeon, HMS Orthopedics, Fortuna.

HEALTH DEPARTMENT UPDATE was presented by Public Health Officer.

-as a result of many local efforts, reported that the County has agreed to support local Needle Exchange Programs, which have proven to make an impact locally.

REPORTED on local Disaster Preparedness and the availability of grant funding to develop Disaster Preparedness outreach, coordination and activities. Agreed that there is a need to increase communications with local physicians.

DISCUSSION was held regarding the various tests that can be ordered through the Public Health Lab and the vaccines that are available through Public Health. Mentioned plans to increase communication on services available to patients through Public Health at low costs.

There being no further business, the meeting was adjourned at 8:40 P.M. Next meeting is scheduled for April 18, 2012.

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

Also refer to Practice Opportunities on our website www.hdncms.org

WANTED - REDWOODS RURAL HEALTH CENTER is seeking a full-time Family Practice Physician or Internist. Join our visionary team and practice patient-centered medicine utilizing a high-quality EHR while engulfing yourself in the stunning natural beauty of Southern Humboldt County. Our dedicated and compassionate team strives to meet the needs of the whole person - body, mind and spirit – for a diverse range patients and conditions by delivering high-quality, responsive medical, dental, behavioral health, and acupuncture services. Rotating after-hour phone-only call, no OB, and no hospital duty, although privileges must be maintained at the local hospital. Visit our website - http://www.rrhc.org/. CVs should be submitted to Tina Tvedt, 101 West Coast Rd./ PO Box 769, Redway, CA, 95560; (707)923-2783 or ttvedt@rrhc.org. *(wj512)*

WANTED ADVANCED PRACTICE CLINICIAN for multi-clinician Family Practice office with >20 years of experience, 2 locations; Fortuna and Ferndale, on the beautiful Northern Coast of California. Competitive salary and benefits package, Rural Health Clinic with federal loan payback options, equal opportunity employer. Minimum of 2 years experience required. For more information please call, 530-941-7612, or fax CV to 707-725-2978. *(db911)*

FNP/NP or PA-C NEEDED. Pt time with option of full-time. Inpatient experience preferred, but not required. Contact Nina, 725-4477. *(rr1011)*

WANTED - FAMILY PRACTICE PHYSICIAN Full or part time. Aviation Medical Examiner preferred. Contact George Jutila, M.D., 725-3334 or home.md@suddenlink.net *(GJ)*

CNM NEEDED. *Contact Barb 725-6108. (ja512)*

PROPERTY FOR SALE/ RENT/ LEASE

3 BR/1Ba. $1100. McK: Close to highway/town/beach/trail. W/D hookups, good neighborhood, nice yard, garage. Includes yard maint/garbage service. Please call 499-5947

FOR LEASE: Join our new professional medical facilities near Mad River Hospital. Build to suit in new Planned Unit Development. 1200 - 4000 sq. ft. spaces. Contact Mark , 707-616-4416 or e-mail: Jones202@suddenlink.net.

MEDICAL OFFICE SPACE AVAILABLE - LEASE.
2504 Harrison Avenue, Eureka. Call: (916) 261-8088.

MISCELLANEOUS

FIREWOOD FOR SALE. Call (707) 499-2805

ARE YOU A CONSORTIUM MEMBER?

Our Consortium for Continuing Medical Education is accredited by the CMA Institute for Medical Quality to plan and accredit local programs to meet the needs of our physicians. Credit is provided for Grand Rounds, Tumor Board, Cardiac Cath Lab, UCSF Case Conference, Neo-Natal Resuscitation, etc. In addition to coordinating programs based on the feedback we get from the membership, we also work with the HDN Foundation/IPA, Hospice, Public Health and other local agencies in coordinating CME credit for physicians.

HELP SUPPORT LOCAL EDUCATION - BE A CONSORTIUM MEMBER